South Dakota Department of Social Services

Strong Families - South Dakota's Foundation and Our Future

Application for Resource Assessment, Long-Term Care, or other Related Medical Assistance

THINGS TO KNOW

Use this application to see what coverage you qualify for

- Medicaid can help meet the medical costs of individuals in need for Long-Term Care (LTC) services. Generally, an individual must use most of his/her own resources before Medicaid will pay for LTC services
- For married individuals, there are different rules which recognize the importance of protecting a portion of a couple's total resources and evaluating the income needs of the spouse who resides in the community. This application can also be used to complete a resource assessment without applying for Medicaid

Who can use this application?

- Single individuals who are in need of Long-Term Care or other related Medical Assistance
- Married individuals or couples who are in need of Long-Term Care or other related Medical Assistance
- Married couples who wish to receive a Resource Assessment

NOTE: Married couples may request a Resource Assessment without applying for Medicaid by marking "Resource Assessment Only" in Section 6. The purpose of the Resource Assessment is to determine how much of a married couple's total resources may be protected or set aside for the community spouse, and how much, if any, must be spent before the individual may be found eligible for LTC Medicaid. Completing the Resource Assessment will help you to protect the maximum amount of your resources under the law.

Learn more online

You can learn more about eligibility for Medical Assistance programs at https://dss.sd.gov/medicaid/Eligibility/default.aspx

What you may need to apply

- Your Social Security number (or document number if you're an eligible immigrant)
- Employer and income information (for example, from paystubs, W-2 forms, or wage and tax statements)
- Resource information (for example, bank statements, insurance contracts, and other contractual agreements)

Why do we ask for this information?

We ask about income and other information to let you know what coverage you qualify for and if you can get any help paying for it.

We'll keep all the information you provide private and secure, as required by law. To view our Notice of Privacy Practices, go to dss.sd.gov/keyresources/hipaa/

What happens next?

Send your complete, signed application to your local DSS office. **If you don't have all the information we ask for, sign and submit your application anyway.** We'll follow up with you. Filling out this application doesn't mean you have to accept health coverage.

Get help with this application

- **Online:** dss.sd.gov
- **Phone:** Call your local office dss.sd.gov/findyourlocaloffice/
- **In person:** Visit your local office dss.sd.gov/findyourlocaloffice/

Language Assistance

1. **Español (Spanish) -** ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-305- 9673 (TTY: 711).
2. **Deutsch (German) -** ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-305-9673 (TTY: 711).
3. **繁體中文 (Chinese) -** 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-305-9673（TTY：711）
4. **unD (Karen)** - Ymol.ymo;=erh>uwdR unD usdmtCd< erRM> usdmtw>rRpXRvX wvXmbl.vXmphR eDwrHRb.ohM.vDRI ud; 1-800-305-9673 (TTY: 711).
5. **Tiếng Việt (Vietnamese) -** CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-305-9673 (TTY: 711).
6. **नेपाली (Nepali) -** ध्यान दनहु ोस:् तपाइले नेपाल बोल्नहन्छ भन तपाइको ननम्त भाषा सहायता सवाहरू नःशल्क रूपमा उपलब्ध छ । फोन गनहु ोसर ्1-800-305-9673 (टटवाइ: 711)
7. **Srpsko-hrvatski (Serbo-Croatian) -** OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-800-305-9673 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711).
8. **አማርኛ (Amharic) -** ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-800-305-9673 (መስማት ለተሳናቸው: 711).
9. Sudanic **Adamawa (Fulfulde)** MAANDO: To a waawi [Adamawa], e woodi ballooji-ma to ekkitaaki wolde caahu. Noddu 1-800-305-9673 (TTY: 711).
10. **Tagalog (Tagalog – Filipino) -** PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-305-9673 (TTY: 711).
11. **한국어 (Korean) -** 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-305-9673 (TTY: 711)번으로 전화해 주십시오.
12. **Русский (Russian) -** ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800- 305-9673 (телетайп: 711).
13. **Cushite Oroomiffa (Oromo) -** XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-305-9673 (TTY: 711).
14. Український (Ukrainian) - УВАГА: Якщо ви говорити українською мовою, перекладацькі послуги, безкоштовно, доступні для вас. Телефонуйте. Телефонуйте 1-800-305-9643 (TTY: 711).
15. **Français (French) -** ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800- 305-9673 (ATS : 711).

1. Information About You and Your Spouse (If Applicable)

FIRST NAME	MI	LAST NAME	DATE OF BIRTH	DATE OF DEATH

GENDER ☐ MALE ☐ FEMALE

MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ SEPARATED ☐ WIDOWED

SOCIAL SECURITY NUMBER

IF YOU DON'T HAVE A SOCIAL SECURITY NUMBER, HAVE YOU APPLIED FOR ONE? ☐ YES ☐ NO

ARE YOU A VETERAN? ☐ YES ☐ NO

ARE YOU A U.S. CITIZEN OR NATIONAL? ☐ YES ☐ NO

IF NO, WHAT IS YOUR IMMIGRATION STATUS?

IMMIGRATION DOCUMENT TYPE	ALIEN ID NUMBER	PASSPORT NUMBER

DATE YOU ENTERED THE U.S. (MM/DD/YYYY)	DO YOU HAVE A SPONSOR? ☐ YES ☐ NO	IF YES, SPONSOR NAME

RACE (OPTIONAL)
☐ NATIVE AMERICAN OR ALASKAN NATIVE ☐ BLACK OR AFRICAN AMERICAN
☐ HAWAIIAN OR PACIFIC ISLANDER ☐ WHITE ☐ ASIAN ☐ OTHER

HISPANIC OR LATINO? (OPTIONAL) ☐ YES ☐ NO

IF NATIVE AMERICAN OR ALASKAN NATIVE, HAVE YOU RECEIVED OR ARE YOU ELIGIBLE TO RECEIVE SERVICES FROM INDIAN HEALTH SERVICES (IHS), URBAN INDIAN HEALTH OR OTHER TRIBAL HEALTHCARE SERVICES? ☐ YES ☐ NO

DO YOU PLAN TO FILE A TAX RETURN? ☐ YES ☐ NO

IF YES, DO YOU PLAN TO FILE JOINTLY WITH A SPOUSE? ☐ YES ☐ NO

LIST ANY PERSON(S) YOU PLAN TO CLAIM AS A DEPENDENT ON YOUR TAX RETURN.

SPOUSE FIRST NAME	MI	SPOUSE LAST NAME	DATE OF BIRTH	DATE OF DEATH

GENDER ☐ MALE ☐ FEMALE

MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ SEPARATED ☐ WIDOWED

SOCIAL SECURITY NUMBER

IF YOU DON'T HAVE A SOCIAL SECURITY NUMBER, HAVE YOU APPLIED FOR ONE? ☐ YES ☐ NO

IS YOUR SPOUSE A VETERAN? ☐ YES ☐ NO

IS YOUR SPOUSE A U.S. CITIZEN OR NATIONAL? ☐ YES ☐ NO

IF NO, WHAT IS YOUR SPOUSE'S IMMIGRATION STATUS?

IMMIGRATION DOCUMENT TYPE	ALIEN ID NUMBER	PASSPORT NUMBER

DATE YOU ENTERED THE U.S. (MM/DD/YYYY)	DO YOU HAVE A SPONSOR? ☐ YES ☐ NO	IF YES, SPONSOR NAME

RACE (OPTIONAL)
☐ NATIVE AMERICAN OR ALASKAN NATIVE ☐ BLACK OR AFRICAN AMERICAN
☐ HAWAIIAN OR PACIFIC ISLANDER ☐ WHITE ☐ ASIAN ☐ OTHER

HISPANIC OR LATINO? (OPTIONAL) ☐ YES ☐ NO

IF NATIVE AMERICAN OR ALASKAN NATIVE, HAVE YOU RECEIVED OR ARE YOU ELIGIBLE TO RECEIVE SERVICES FROM INDIAN HEALTH SERVICES (IHS), URBAN INDIAN HEALTH OR OTHER TRIBAL HEALTHCARE SERVICES? ☐ YES ☐ NO

2. Dependents

DO YOU OR YOUR SPOUSE HAVE ANY CHILDREN OR OTHER DEPENDENTS LIVING WITH YOU?*

☐ YES ☐ NO

NAME OF DEPENDENT	RELATIONSHIP	GENDER ☐ MALE ☐ FEMALE
DATE OF BIRTH (MM/DD/YYYY)	SOCIAL SECURITY NUMBER	IS THIS PERSON DISABLED? ☐ YES ☐ NO
US CITIZEN? ☐ YES ☐ NO	RACE ☐ NATIVE AMERICAN OR ALASKAN NATIVE ☐ BLACK OR AFRICAN AMERICAN ☐ HAWAIIAN OR PACIFIC ISLANDER ☐ WHITE ☐ ASIAN ☐ OTHER	
GROSS INCOME	SOURCE	FREQUENCY

NAME OF DEPENDENT	RELATIONSHIP	GENDER ☐ MALE ☐ FEMALE
DATE OF BIRTH (MM/DD/YYYY)	SOCIAL SECURITY NUMBER	IS THIS PERSON DISABLED? ☐ YES ☐ NO
US CITIZEN? ☐ YES ☐ NO	RACE ☐ NATIVE AMERICAN OR ALASKAN NATIVE ☐ BLACK OR AFRICAN AMERICAN ☐ HAWAIIAN OR PACIFIC ISLANDER ☐ WHITE ☐ ASIAN ☐ OTHER	
GROSS INCOME	SOURCE	FREQUENCY

*If you have more than two children or dependents living with you, copy this page and complete the information above for each.

3. Contact Information for You

RESIDENTIAL ADDRESS			
CITY	STATE	COUNTY	ZIP CODE
MAILING ADDRESS (IF DIFFERENT FROM RESIDENTIAL ADDRESS)			
CITY	STATE	COUNTY	ZIP CODE
PHONE NUMBER	E-MAIL ADDRESS		

4. Contact Information for Your Spouse (If Applicable)

SPOUSE RESIDENTIAL ADDRESS			
CITY	STATE	COUNTY	ZIP CODE
SPOUSE MAILING ADDRESS (IF DIFFERENT FROM RESIDENTIAL ADDRESS)			
CITY	STATE	COUNTY	ZIP CODE
SPOUSE PHONE NUMBER	SPOUSE E-MAIL ADDRESS		

5. Person Helping you Complete this Form

IS SOMEONE HELPING YOU FILL OUT THIS FORM? IF YOU WANT SOMEONE TO RECEIVE INFORMATION ABOUT YOUR APPLICATION, PLEASE COMPLETE SECTION 46 AT THE END OF THIS APPLICATION.

☐ YES ☐ NO

IF YES, NAME	RELATIONSHIP OR ORGANIZATION
MAILING ADDRESS	

CITY	STATE	ZIP CODE
PHONE NUMBER	E-MAIL ADDRESS	

6. Benefits You are Applying for

WHO ARE YOU APPLYING FOR?	DO YOU KNOW WHAT TYPE OF BENEFIT YOU WISH TO APPLY FOR? IF YES, PLEASE INDICATE THE TYPE BELOW.
☐ SELF ☐ SPOUSE	☐ YES ☐ NO

☐ NURSING FACILITY ☐ ASSISTED LIVING FACILITY ☐ HOSPITALIZATION ☐ IN-HOME SERVICES

☐ GROUP HOME ☐ FAMILY SUPPORT WAIVER ☐ RESOURCE ASSESSMENT ONLY ☐ DISABLED CHILDREN'S PROGRAM

☐ CHRONIC RENAL DISEASE PROGRAM ☐ MAWD

7. Medical Assistance Start Date

DO YOU WANT ASSISTANCE PAYING FOR MEDICAL BILLS IN THE PAST THREE (3) MONTHS?*

☐ YES ☐ NO

IF YES, HOW MANY MONTHS IN THE PAST DO YOU NEED ASSISTANCE?

☐ ONE ☐ TWO ☐ THREE

* You must provide copies of unpaid medical bills as well as documentation of your income and assets for the prior months you wish to have covered

8. Facility Information for You

DO YOU CURRENTLY LIVE IN A FACILITY OR EXPECT TO LIVE IN A FACILITY?

☐ YES ☐ NO

IF YES, WHAT TYPE OF FACILITY?

☐ NURSING HOME ☐ ASSISTED LIVING CENTER ☐ GROUP HOME FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES

☐ HOSPITAL ☐ OTHER

FACILITY NAME	FACILITY ADDRESS	
ADMISSION DATE (MM/DD/YYYY)	HAVE YOU ALREADY BEEN DISCHARGED? ☐ YES ☐ NO	DISCHARGE DATE (MM/DD/YYYY)

DO YOU PLAN TO RETURN HOME WITHIN SIX (6) MONTHS? IF YES, PROVIDE LETTER FROM PHYSICIAN

☐ YES ☐ NO

WERE YOU IN THE HOSPITAL PRIOR TO MOVING TO A FACILITY OR RECEIVING SERVICES IN YOUR HOME?

☐ YES ☐ NO

IF YES, DATE YOU WERE ADMITTED TO THE HOSPITAL (MM/DD/YYYY)

9. Facility Information for Your Spouse (If Applicable)

DO YOU CURRENTLY LIVE IN A FACILITY OR EXPECT TO LIVE IN A FACILITY?

☐ YES ☐ NO

IF YES, WHAT TYPE OF FACILITY?

☐ NURSING HOME ☐ ASSISTED LIVING CENTER ☐ GROUP HOME FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES

☐ HOSPITAL ☐ OTHER

FACILITY NAME	FACILITY ADDRESS	
ADMISSION DATE (MM/DD/YYYY)	HAVE YOU ALREADY BEEN DISCHARGED? ☐ YES ☐ NO	DISCHARGE DATE (MM/DD/YYYY)

DO YOU PLAN TO RETURN HOME WITHIN SIX (6) MONTHS? IF YES, PROVIDE LETTER FROM PHYSICIAN

☐ YES ☐ NO

WERE YOU IN THE HOSPITAL PRIOR TO MOVING TO A FACILITY OR RECEIVING SERVICES IN YOUR HOME?

☐ YES ☐ NO

IF YES, DATE YOU WERE ADMITTED TO THE HOSPITAL (MM/DD/YYYY)

10. Medical Information

DO YOU OR YOUR SPOUSE HAVE A PHYSICAL, MENTAL, OR EMOTIONAL HEALTH CONDITION THAT CAUSES LIMITATIONS IN ACTIVITIES (LIKE BATHING, DRESSING, DAILY CHORES, ETC.)? IF NO, LEAVE BLANK.

☐ SELF ☐ SPOUSE

IF YES, PROVIDE YOUR DOCTOR'S NAME BELOW.

YOUR DOCTOR'S NAME	SPOUSE DOCTOR'S NAME

ARE YOU APPLYING FOR A CHILD LIVING IN THE HOME WHO HAS A SKILLED NURSING NEED PROVIDED BY THE PARENT/GUARDIAN?

☐ YES ☐ NO

IF YES, ANSWER THE TWO QUESTIONS BELOW.

WHAT IS THE CHILD'S PRIMARY DIAGNOSIS?	WHAT IS THE CHILD'S PROGNOSIS?

HAVE YOU OR YOUR SPOUSE BEEN DIAGNOSED WITH END STAGE RENAL DISEASE? IF NO, LEAVE BLANK.

☐ SELF ☐ SPOUSE

IF YES, ANSWER THE TWO QUESTIONS BELOW.

DO YOU RECEIVE DIALYSIS? ☐ YES ☐ NO	HAVE YOU RECEIVED A TRANSPLANT? ☐ YES ☐ NO
WHAT DATE DID DIALYSIS BEGIN?	WHAT DATE WAS THE TRANSPLANT?

11. Medicare

DO YOU OR YOUR SPOUSE HAVE MEDICARE? IF YES, PLEASE COMPLETE BELOW

☐ YES ☐ NO

	YOU	**SPOUSE**
PLAN TYPE	☐ PART A ☐ PART B ☐ PART D	☐ PART A ☐ PART B ☐ PART D
PART D PLAN NAME (IF APPLICABLE)		

12. Income from Sources Other Than Employment

DO YOU OR YOUR SPOUSE RECEIVE MONEY FROM SOURCES OTHER THAN WORK? THESE INCLUDE THE FOLLOWING:

- SOCIAL SECURITY
- SUPPLEMENTAL SECURITY INCOME (SSI)
- RETIREMENT ACCOUNTS
- PENSION FUNDS
- SPOUSAL SUPPORT
- WORKER'S COMPENSATION
- UNEMPLOYMENT
- VETERANS' BENEFITS
- RENTAL INCOME
- ANNUITIES
- TRUSTS
- ROYALTIES
- OTHER SOURCES

☐ YES ☐ NO

NAME	TYPE OF INCOME	AMOUNT	HOW OFTEN
		$	
		$	
		$	
		$	
		$	

* You must provide verification of any income listed above. This may include award letters, benefit statements, rental agreements, etc.

13. Application for Other Benefits

ARE YOU OR YOUR SPOUSE WAITING ON AN APPLICATION FOR ONE OF THE PROGRAMS LISTED BELOW?

☐ YES ☐ NO

SOCIAL SECURITY ☐ YES ☐ NO	NAME OF PERSON
SUPPLEMENTAL SECURITY INCOME ☐ YES ☐ NO	NAME OF PERSON
VETERANS' BENEFITS ☐ YES ☐ NO	NAME OF PERSON
OTHER BENEFITS ☐ YES ☐ NO	NAME OF PERSON

14. Employment Income

DO YOU OR YOUR SPOUSE RECEIVE INCOME FROM A JOB?*

☐ YES ☐ NO

NAME OF PERSON WORKING	EMPLOYER NAME	
IS THIS JOB TEMPORARY? ☐ YES ☐ NO	HAS THIS JOB ENDED? ☐ YES ☐ NO	IF YES, END DATE (MM/DD/YYYY)
AMOUNT OF INCOME BEFORE TAXES	HOW OFTEN?	

* You must provide a copy of paystubs covering the most recent month with your application

15. Self-Employment

ARE YOU OR YOUR SPOUSE SELF-EMPLOYED?*

☐ YES ☐ NO

NAME OF SELF-EMPLOYED PERSON	BUSINESS NAME
MONTHLY INCOME	MONTHLY EXPENSES

* You must provide a copy of your most recent tax return with your application

16. Vehicles

DO YOU OR YOUR SPOUSE HAVE ANY CARS, TRUCKS, BOATS, OR OTHER RECREATIONAL VEHICLES?

☐ YES ☐ NO

OWNER NAME(S)	MAKE/MODEL	YEAR	VALUE	AMOUNT OWED
			$	$
			$	$
			$	$
			$	$
			$	$
			$	$

IF MORE THAN ONE VEHICLE IS LISTED ABOVE, WHICH DO YOU USE AS YOUR PRIMARY METHOD OF TRANSPORTATION?

17. Burial Funds

DO YOU OR YOUR SPOUSE HAVE ANY BANK ACCOUNTS DESIGNATED FOR BURIAL, PREPAID BURIAL CONTRACTS, TRUSTS OR OTHER FINANCIAL ARRANGEMENTS FOR SERVICES?*

☐ YES ☐ NO

NAME OF THE ORGANIZATION WHO KEEPS THE FUNDS	DATE PURCHASED (MM/DD/YYYY)	VALUE
CITY	STATE	ZIP

NAME OF THE ORGANIZATION WHO KEEPS THE FUNDS	DATE PURCHASED (MM/DD/YYYY)	VALUE
CITY	STATE	ZIP

* You must provide a copy of any burial account statements, contracts, etc. with your application

18. Home Property

DO YOU OR YOUR SPOUSE OWN A HOME (INCLUDING A MOBILE HOME)?*

☐ YES ☐ NO

OWNER NAME(S)	VALUE	AMOUNT OWED

ADDRESS	CITY	STATE	ZIP

DO YOU HAVE A REVERSE MORTGAGE ON YOUR HOME?

☐ YES ☐ NO

IF YES, DID YOU RECEIVE A LUMP SUM? ☐ YES ☐ NO	HOW MUCH?
IF YES, DO YOU RECEIVE A MONTHLY PAYMENT? ☐ YES ☐ NO	HOW MUCH?

* You must provide a copy of the latest real estate tax assessment and verification of any outstanding debt on the property with your application

19. Other Real Estate

DO YOU OR YOUR SPOUSE OWN OR SHARE OWNERSHIP OF ANY OTHER LAND, LOTS, OR OTHER REAL ESTATE?*

☐ YES ☐ NO

OWNER NAME(S)	VALUE	AMOUNT OWED	
ADDRESS	CITY	STATE	ZIP

OWNER NAME(S)	VALUE	AMOUNT OWED	
ADDRESS	CITY	STATE	ZIP

* You must provide a copy of the latest real estate tax assessment with your application

20. Life Estates

DO YOU OR YOUR SPOUSE HAVE A LIFE ESTATE OR REMAINDER INTEREST IN PROPERTY?

☐ YES ☐ NO

OWNER NAME(S)	TYPE OF PROPERTY	VALUE	
ADDRESS	CITY	STATE	ZIP

OWNER NAME(S)	TYPE OF PROPERTY	VALUE	
ADDRESS	CITY	STATE	ZIP

21. Partnerships and Corporations

DO YOU OR YOUR SPOUSE HAVE ANY INTEREST IN A PARTNERSHIP OR CORPORATION?

☐ YES ☐ NO

OWNER NAME(S)	NAME OF PARTNERSHIP OR CORPORATION
OWNERSHIP INTEREST PERCENTAGE	VALUE

22. Other Property

DO YOU OR YOUR SPOUSE OWN ANY BUSINESS EQUIPMENT, MACHINERY, LIVESTOCK, ANTIQUES, COLLECTIONS, OR OTHER VALUED PROPERTY?

☐ YES ☐ NO

TYPE OF ITEM	VALUE
TYPE OF ITEM	VALUE

23. Cash on Hand or in a Safety Deposit Box

DO YOU OR YOUR SPOUSE HAVE CASH ON HAND OR IN A SAFETY DEPOSIT BOX? ☐ YES ☐ NO	VALUE

24. Bank Accounts

DO YOU OR YOUR SPOUSE HAVE ANY BANK ACCOUNTS, SUCH AS CHECKING, SAVINGS, MONEY MARKET ACCOUNTS OR CERTIFICATES OF DEPOSIT (CD)?*

☐ YES ☐ NO

OWNER NAME(S)	TYPE OF ACCOUNT	BANK NAME	BANK ADDRESS	ACCOUNT NUMBER	VALUE
					$
					$
					$
					$
					$
					$

* You must provide the last three (3) months of statements for each account listed with your application

25. Nursing Home Resident Accounts

DO YOU OR YOUR SPOUSE HAVE A NURSING HOME OR RESIDENT ACCOUNT WITH A FACILITY?

☐ YES ☐ NO

NAME OF THE ORGANIZATION WHO KEEPS THE FUNDS		VALUE
CITY	STATE	ZIP

26. Health Savings Accounts

DO YOU OR YOUR SPOUSE HAVE ANY HEALTH SAVINGS ACCOUNT(S)?*

☐ YES ☐ NO

OWNER NAME(S)	BANK NAME	BANK ADDRESS	ACCOUNT NUMBER	VALUE
				$
				$

* You must provide the last three (3) months of statements for each account listed with your application

27. Employee Payroll Debit Card or Direct Express Federal Benefit Cards

DO YOU OR YOUR SPOUSE HAVE AN EMPLOYEE PAYROLL DEBIT CARD OR DIRECT EXPRESS FEDERAL BENEFIT CARD?

☐ YES ☐ NO

OWNER NAME(S)	ACCOUNT NUMBER	
BANK OR COMPANY NAME	VALUE	
CITY	STATE	ZIP

28. Retirement Accounts

DO YOU OR YOUR SPOUSE HAVE ANY 401(K), INDIVIDUAL RETIREMENT ACCOUNTS (IRA), 403(B), 457(B), OR OTHER RETIREMENT ACCOUNT(S)? IF YOU HAVE PENSION, PLEASE SEE QUESTION 13.*

☐ YES ☐ NO

OWNER NAME(S)	BANK/COMPANY NAME	BANK/COMPANY ADDRESS	ACCOUNT NUMBER	VALUE
				$
				$

* You must provide the last three (3) months of statements for each account listed with your application

29. Pension Funds

DO YOU OR YOUR SPOUSE HAVE ANY PENSION FUNDS?

☐ YES ☐ NO

OWNER NAME(S)	BANK/COMPANY NAME	BANK/COMPANY ADDRESS	ACCOUNT NUMBER	VALUE
				$
				$

30. Savings Bonds

DO YOU OR YOUR SPOUSE HAVE ANY SAVINGS BONDS?*

☐ YES ☐ NO

OWNER NAME(S)	SERIES	SERIAL NUMBER	ISSUE DATE	DENOMINATION
				$
				$
				$

* You must provide a copy of each bond listed with your application

31. Stocks or Mutual Funds

DO YOU OR YOUR SPOUSE HAVE ANY STOCK OR MUTUAL FUND ACCOUNT(S)?*

☐ YES ☐ NO

OWNER NAME(S)	BANK/COMPANY NAME	BANK/COMPANY ADDRESS	ACCOUNT NUMBER	VALUE
				$
				$

* You must provide the last three (3) months of statements for each account listed with your application

32. Promissory Notes and Contracts for Deed

DO YOU OR YOUR SPOUSE HAVE ANY PROMISSORY NOTES OR CONTRACTS FOR DEED?*

☐ YES ☐ NO

OWNER NAME(S)	OUTSTANDING PRINCIPAL AMOUNT

ADDRESS	CITY	STATE	ZIP

* You must provide a copy of contract and an amortization schedule with your application

33. Mineral, Oil, Gas, Timber, Wind, or Surface Rights

DO YOU OR YOUR SPOUSE HAVE ANY MINERAL, OIL, GAS, TIMBER, WIND, OR SURFACE RIGHTS?*

☐ YES ☐ NO

OWNER NAME(S)	TYPE	VALUE

ADDRESS	CITY	STATE	ZIP

OWNER NAME(S)	TYPE	VALUE

ADDRESS	CITY	STATE	ZIP

* You must provide documentation to support the value provided. This may be an estimate from a real estate broker, mining company, Bureau of Land Management, or other reputable sources

34. Life Insurance

DO YOU OR YOUR SPOUSE OWN ANY LIFE INSURANCE POLICIES?

☐ YES ☐ NO

NAME OF INSURED PERSON (FIRST NAME, MI, LAST NAME)	NAME OF POLICY OWNER

POLICY START DATE	FACE VALUE	CASH VALUE

INSURANCE COMPANY NAME	POLICY NUMBER

ADDRESS	CITY	STATE	ZIP

NAME OF INSURED PERSON (FIRST NAME, MI, LAST NAME)	NAME OF POLICY OWNER

POLICY START DATE	FACE VALUE	CASH VALUE

INSURANCE COMPANY NAME	POLICY NUMBER

ADDRESS	CITY	STATE	ZIP

35. Long Term Care Insurance

DO YOU OR YOUR SPOUSE HAVE LONG TERM CARE INSURANCE? IF YES, PLEASE COMPLETE BELOW

☐ YES ☐ NO

IS THIS A PARTNERSHIP PLAN?

☐ YES ☐ NO ☐ UNSURE

NAME OF INSURED PERSON	NAME OF POLICY HOLDER

INSURANCE COMPANY NAME	POLICY NUMBER	POLICY START DATE

COMPANY ADDRESS	CITY	STATE	ZIP

HOW MUCH IS THE PREMIUM?	HOW OFTEN IS THE PREMIUM PAID?
	☐ MONTHLY ☐ QUARTERLY ☐ YEARLY

36. Private Health Insurance

DO YOU OR YOUR SPOUSE HAVE PRIVATE HEALTH INSURANCE OR MEDICARE SUPPLEMENTAL INSURANCE?

☐ YES ☐ NO

NAME OF INSURED PERSON	NAME OF POLICY HOLDER

INSURANCE COMPANY NAME	POLICY NUMBER	POLICY START DATE

COMPANY ADDRESS	CITY	STATE	ZIP

HOW MUCH IS THE PREMIUM?	HOW OFTEN IS THE PREMIUM PAID?	TYPE OF COVERAGE (MEDIGAP, RX, ETC)
	☐ MONTHLY ☐ QUARTERLY ☐ YEARLY	

DO YOU GET THIS INSURANCE THROUGH AN EMPLOYER?	IF YES, LIST EMPLOYER'S NAME
☐ YES ☐ NO	

37. Trusts

ARE YOU OR YOUR SPOUSE NAMED IN ANY TRUSTS OR DO YOU OR YOUR SPOUSE HAVE OWNERSHIP OF ANY TRUSTS?*

☐ YES ☐ NO

OWNER NAME(S)	BANK NAME	BANK ADDRESS	ACCOUNT NUMBER	VALUE
				$
				$

* You must provide a copy of the trust and an inventory of trust assets with your application

38. Annuities

DO YOU OR YOUR SPOUSE OWN ANY ANNUITIES?*

☐ YES ☐ NO

OWNER NAME(S)	BANK NAME	BANK ADDRESS	ACCOUNT NUMBER	VALUE
				$
				$

* You must provide a copy of the annuity contract with your application. Please read Disclosure of Annuities and State to be Named as Remainder Beneficiary section of the Statement of Understanding page.

39. Transfer of Resources

IN THE LAST SIXTY (60) MONTHS, HAVE YOU, YOUR SPOUSE, OR ANYONE ACTING ON BEHALF OF YOU OR YOUR SPOUSE (E.G. FAMILY MEMBERS, GUARDIAN, POWER OF ATTORNEY), TRANSFERRED, GIVEN AWAY, GIFTED, LOANED, SOLD, OR DEEDED ANYTHING OF VALUE TO SOMEONE ELSE?

☐ YES ☐ NO

TYPE OF ITEM	VALUE	AMOUNT RECEIVED

WHO RECEIVED THE ITEM	DATE SOLD OR TRANSFERRED (MM/DD/YYYY)

ADDRESS	CITY	STATE	ZIP

TYPE OF ITEM	VALUE	AMOUNT RECEIVED

WHO RECEIVED THE ITEM	DATE SOLD OR TRANSFERRED (MM/DD/YYYY)

ADDRESS	CITY	STATE	ZIP

40. Income and Resources You Chose not to Receive

IN THE LAST SIXTY (60) MONTHS, DID YOU OR YOUR SPOUSE GIVE UP THE RIGHT TO GET ANY MONEY (E.G. INCOME OR INHERITANCE)?

☐ YES ☐ NO

TYPE OF ITEM	VALUE
PLEASE EXPLAIN	

41. Joint Ownership

IN THE LAST SIXTY (60) MONTHS, DID YOU OR YOUR SPOUSE ESTABLISH JOINT OWNERSHIP IN ANY REAL PROPERTY?

☐ YES ☐ NO

TYPE OF PROPERTY	VALUE
NAME OF JOINT OWNER	DATE JOINT OWNERSHIP ESTABLISHED (MM/DD/YYYY)

IN THE LAST SIXTY (60) MONTHS, HAS A JOINT OWNER TAKEN POSSESSION OF THEIR SHARE IN ANY OF YOU OR YOUR SPOUSE'S ASSETS SUCH AS MONEY, BANK ACCOUNTS, STOCKS, BONDS, OR ANYTHING ELSE OF VALUE?

☐ YES ☐ NO

TYPE OF RESOURCE	VALUE
NAME OF JOINT OWNER	DATE TAKEN (MM/DD/YYYY)

42. Resources and Income Placed in Trust

IN THE LAST SIXTY (60) MONTHS, WERE ANY OF YOU OR YOUR SPOUSES RESOURCES OR PROPERTY PLACED INTO A TRUST FOR YOU, YOUR SPOUSE, OR ANYONE ELSE?

☐ YES ☐ NO

NAME OF TRUSTEE	DATE TRANSFERRED TO TRUST (MM/DD/YYYY)
TYPE OF PROPERTY	VALUE

IS ANY OF YOUR INCOME PAID DIRECTLY INTO A TRUST?

☐ YES ☐ NO

NAME OF TRUSTEE	DATE TRUST ESTABLISHED (MM/DD/YYYY)
SOURCE OF INCOME	AMOUNT PAID TO TRUST

43. Housing Costs

DO YOU OR YOUR SPOUSE HAVE HOUSING OR SHELTER COSTS?

☐ YES ☐ NO

	YOU PAY	SPOUSE PAYS	OTHER: LIST NAME
RENT OR MORTGAGE			
PROPERTY TAXES			
UTILITIES			
HOMEOWNERS INSURANCE			

44. Statement of Understanding

ASSIGNMENT OF MEDICAL SUPPORT AND INSURANCE PROCEEDS
AN APPLICATION FOR AND ACCEPTANCE OF MEDICAL ASSISTANCE PAID FROM THE DEPARTMENT OF SOCIAL SERVICES SHALL OPERATE AS AN ASSIGNMENT AND SUBROGATION OF ANY RIGHTS TO MEDICAL SUPPORT, INSURANCE PROCEEDS, OR BOTH THAT THE APPLICANT OR RECIPIENT MAY HAVE. ANY RIGHTS OR AMOUNTS SO ASSIGNED OR SUBROGATED SHALL BE APPLIED AGAINST THE COST OF THE APPLICANT'S OR RECIPIENT'S CARE.

DISCLOSURE OF ANNUITIES AND STATE TO BE NAMED AS REMAINDER BENEFICIARY
PUBLIC LAW NO. 109-171 DEFICIT REDUCTION ACT OF 2005 SECTION 6012 REQUIRES INDIVIDUALS APPLYING FOR LONG-TERM CARE MEDICAL ASSISTANCE AND AN INDIVIDUAL WHOSE ELIGIBILITY IS BEING REVIEWED FOR PURPOSES OF DETERMINING WHETHER THE INDIVIDUAL CONTINUES TO BE ELIGIBLE FOR LONG-TERM CARE ASSISTANCE TO DISCLOSE THE DESCRIPTION OF ANY INTEREST THE INDIVIDUAL OR THE INDIVIDUAL'S SPOUSE HAS IN AN ANNUITY OR SIMILAR FINANCIAL INSTRUMENT. FAILURE TO DISCLOSE THIS INFORMATION RESULTS IN INELIGIBILITY FOR ASSISTANCE. IN ADDITION, A RECIPIENT OF LONG TERM CARE ASSISTANCE MUST NAME THE DEPARTMENT AS A PREFERRED REMAINED BENEFICIARY OF ANY INTEREST THE INDIVIDUAL OR INDIVIDUAL'S SPOUSE HAS IN AN ANNUITY OR SIMILAR FINANCIAL INSTRUMENT PURCHASED AND OWNED AFTER FEBRUARY 7, 2006.

PRIVACY ACT STATEMENT
FEDERAL AND STATE LAW AND REGULATIONS LIMIT THE USE AND DISCLOSURE OF CONFIDENTIAL INFORMATION CONCERNING APPLICANTS AND RECIPIENTS OF ECONOMIC AND MEDICAL ASSISTANCE PROGRAMS TO PURPOSES DIRECTLY RELATED TO THE ADMINISTRATION OF THOSE PROGRAMS. WHEN YOU APPLY FOR ASSISTANCE, YOU WILL BE ASKED TO PROVIDE YOUR SOCIAL SECURITY NUMBER (SSN) ON THE APPLICATION FORM. TITLE 42 OF THE CODE OF FEDERAL REGULATIONS PART 435.910(A), REQUIRES THE FURNISHING OF A SSN AS A CONDITION OF ELIGIBILITY FOR MEDICAID. THE DEPARTMENT USES YOUR NUMBER IN ITS COMPUTER PROCESSING OF ELIGIBILITY DETERMINATION, WELFARE FRAUD INVESTIGATION AND AUDITS. SSNS ARE ALSO USED TO VERIFY INCOME INFORMATION THROUGH AGENCIES SUCH AS THE IRS, DEPARTMENT OF LABOR, AND SOCIAL SECURITY ADMINISTRATION, ETC., TO PREVENT A PERSON OR FAMILY FROM RECEIVING DUPLICATE BENEFITS UNDER ANY PROGRAM, TO MAKE MASS CHANGES IN BENEFITS EASIER TO IMPLEMENT AND TO DETERMINE THE ACCURACY AND RELIABILITY OF INFORMATION GIVEN TO THE DEPARTMENT BY APPLICANT FOR AND RECIPIENTS OF ASSISTANCE.

VERIFICATIONS
INFORMATION YOU GIVE TO ANSWER THE QUESTIONS ON THIS FORM, AND INFORMATION OBTAINED BY THE DEPARTMENT TO VERIFY YOUR ANSWERS WILL BE USED TO DETERMINE YOUR ELIGIBILITY AND LEVEL OF BENEFITS. YOUR BENEFITS MAY CHANGE FROM MONTH TO MONTH, OR BE STOPPED, BASED ON THIS INFORMATION.

FEDERAL AND STATE OFFICIALS WILL VERIFY INFORMATION GIVEN ON THIS FORM TO DETERMINE IF IT IS CORRECT. A DEPARTMENT REPRESENTATIVE MAY CONTACT YOU OR MAY CONTACT OTHER PEOPLE IN ORDER TO VERIFY YOUR ELIGIBILITY FOR ASSISTANCE. INFORMATION GIVEN WILL ALSO BE VERIFIED BY COMPUTER CROSS-MATCHING WITH OTHER AGENCIES AND PRIVATE SECTORS. WHEN STATE AND FEDERAL PERSONNEL VERIFY THE INFORMATION ON THIS APPLICATION, IF WHAT IS REPORTED IS FOUND TO BE INCORRECT YOUR MEDICAL CASE MAY BE DENIED OR TERMINATED AND YOU MAY BE SUBJECT TO CRIMINAL PROSECUTION FOR KNOWINGLY PROVIDING FALSE INFORMATION

MEDICAID ESTATE RECOVERY PROGRAM
UNDER FEDERAL AND STATE LAW, THE DEPARTMENT OF SOCIAL SERVICES IS AUTHORIZED TO MAKE RECOVERY FROM THE ESTATES OF DECEASED MEDICAL ASSISTANCE RECIPIENTS WHO WERE PERMANENTLY INSTITUTIONALIZED OR WHO WERE AT LEAST 55 YEARS OF AGE AND FOR WHOM THE DEPARTMENT MADE A PAYMENT FOR NURSING FACILITY SERVICES, INTERMEDIATE CARE FACILITY SERVICES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES, OTHER MEDICAL INSTITUTIONAL SERVICES, HOME AND COMMUNITY BASED SERVICES, HOSPITAL SERVICES, AND PRESCRIPTION DRUG SERVICES. THE DEPARTMENT OF SOCIAL SERVICES IS AUTHORIZED TO RECOVER THE DEBT OF A MEDICAL ASSISTANCE RECIPIENT FROM THE ESTATE OF A SURVIVING SPOUSE. IF A SURVIVING SPOUSE WISHES TO LIMIT THE AMOUNT OF THE SURVIVING SPOUSE'S ESTATE THAT WILL BE LIABLE FOR RECOVERY FOR THE AMOUNT OF MEDICAL ASSISTANCE PAID ON BEHALF OF THE RECIPIENT, THE SURVIVING SPOUSE MUST FILE A PETITION WITHIN SIX MONTHS OF THE DEATH OF THE MEDICAL ASSISTANCE RECIPIENT. THE PETITION WILL DETERMINE THE AMOUNT OF THE SURVIVING SPOUSE'S ESTATE FROM WHICH RECOVERY MAY BE CLAIMED FOR MEDICAID EXPENDED ON BEHALF OF THE RECIPIENT. THE PETITION MUST BE FILED ON THE DEPARTMENT'S FORM.

UNDER FEDERAL AND STATE LAW, THE DEPARTMENT OF SOCIAL SERVICES MAY IMPOSE A MEDICAL ASSISTANCE LIEN AGAINST REAL PROPERTY OWNED BY A RECIPIENT WHO HAS RECEIVED A BENEFIT FROM THE DEPARTMENT OF SOCIAL SERVICES FOR THE SERVICES OF A NURSING FACILITY, AN INTERMEDIATE CARE FACILITY FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES, OR OTHER MEDICAL INSTITUTION. THE DEPARTMENT OF SOCIAL SERVICES WILL ISSUE A SEPARATE NOTICE WHEN THE DEPARTMENT DECIDES TO IMPOSE A LIEN. THE NOTICE WILL DESCRIBE THE AMOUNT OF THE LIEN AND THE REAL PROPERTY TO WHICH THE LIEN IS TO ATTACH. UNDER STATE LAW, THE DEPARTMENT OF SOCIAL SERVICES IS AUTHORIZED TO RECOVER ANY FUNDS OF THE RESIDENT KEPT OR MAINTAINED BY THE NURSING HOME OR OTHER FACILITY IF THE RESIDENT WAS RECEIVING MEDICAL ASSISTANCE FROM THE DEPARTMENT AT THE TIME OF DEATH. INFORMATION IN REGARD TO THE ESTATE RECOVERY PROGRAM, CAN BE LOCATED AT HTTP://DSS.SD.GOV/KEYRESOURCES/BENEFITFRAUD/ESTATE.ASPX

NOTICE OF NONDISCRIMINATION
AS A RECIPIENT OF FEDERAL FINANCIAL ASSISTANCE AND A STATE OR LOCAL GOVERNMENTAL AGENCY, THE DEPARTMENT OF SOCIAL SERVICES DOES NOT EXCLUDE, DENY BENEFITS TO, OR OTHERWISE DISCRIMINATE AGAINST ANY PERSON ON THE GROUND OF RACE, COLOR, OR NATIONAL ORIGIN, OR ON THE BASIS OF DISABILITY OR AGE IN ADMISSION OR ACCESS TO, OR TREATMENT OR EMPLOYMENT IN, ITS PROGRAMS, ACTIVITIES, OR SERVICES, WHETHER CARRIED OUT BY THE DEPARTMENT OF SOCIAL SERVICES DIRECTLY OR THROUGH A CONTRACTOR OR ANY OTHER ENTITY WITH WHICH THE DEPARTMENT OF SOCIAL SERVICES ARRANGES TO CARRY OUT ITS PROGRAMS AND ACTIVITIES; OR ON THE BASIS OF ACTUAL OR PERCEIVED RACE, COLOR, RELIGION, NATIONAL ORIGIN, SEX, GENDER IDENTITY, SEXUAL ORIENTATION OR DISABILITY IN ADMISSION OR ACCESS TO, OR TREATMENT OR EMPLOYMENT IN, ITS PROGRAMS, ACTIVITIES, OR SERVICES WHEN CARRIED OUT BY THE DEPARTMENT OF SOCIAL SERVICES DIRECTLY OR WHEN CARRIED OUT BY SUB-RECIPIENTS OF GRANTS ISSUED BY THE UNITED STATES DEPARTMENT OF JUSTICE, OFFICE ON VIOLENCE AGAINST WOMEN.

THE DEPARTMENT OF SOCIAL SERVICES PROVIDES FREE AIDS AND SERVICES TO PEOPLE WITH DISABILITIES TO COMMUNICATE EFFECTIVELY SUCH AS QUALIFIED SIGN LANGUAGE INTERPRETERS AND WRITTEN INFORMATION IN OTHER FORMATS (E.G. LARGE PRINT, AUDIO, ACCESSIBLE ELECTRONIC FORMATS, OTHER FORMATS) AND PROVIDES FREE LANGUAGE SERVICES TO PEOPLE WHOSE PRIMARY LANGUAGE IS NOT ENGLISH SUCH AS QUALIFIED INTERPRETERS AND INFORMATION WRITTEN IN OTHER LANGUAGES. IF YOU NEED THESE SERVICES, CONTACT YOUR LOCAL DSS OFFICE.

IF YOU BELIEVE THAT DSS HAS FAILED TO PROVIDE THESE SERVICES OR DISCRIMINATED IN ANOTHER WAY ON THE BASIS OF RACE, COLOR, NATIONAL ORIGIN, AGE, DISABILITY, OR SEX, YOU CAN FILE A DISCRIMINATION COMPLAINT OR GRIEVANCE WITH: DISCRIMINATION COORDINATOR, DIRECTOR OF DSS DIVISION OF LEGAL SERVICES, 700 GOVERNORS DRIVE, PIERRE, SD 57501. PHONE: (605) 773-3305, FAX: (605) 773-7223, DSSINFO@STATE.SD.US. YOU CAN FILE A DISCRIMINATION COMPLAINT OR GRIEVANCE IN PERSON OR BY MAIL, FAX, OR EMAIL. IF YOU NEED HELP FILING A DISCRIMINATION COMPLAINT OR GRIEVANCE, THE DISCRIMINATION COORDINATOR, DIRECTOR OF DSS DIVISION OF LEGAL SERVICES IS AVAILABLE TO HELP YOU.

YOU CAN ALSO FILE A CIVIL RIGHTS COMPLAINT WITH THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, OFFICE FOR CIVIL RIGHTS, ELECTRONICALLY THROUGH THE OFFICE FOR CIVIL RIGHTS COMPLAINT PORTAL, AVAILABLE AT HTTPS://OCRPORTAL.HHS.GOV/OCR/PORTAL/LOBBY.JSF, OR BY MAIL OR PHONE AT: U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES 200 INDEPENDENCE AVENUE, SW ROOM 509F, HHH BUILDING WASHINGTON, D.C. 20201 1-800-368-1019, 800-537-7697 (TDD) COMPLAINT FORMS ARE AVAILABLE AT HTTP://WWW.HHS.GOV/OCR/OFFICE/FILE/INDEX.HTML.

THIS STATEMENT IS IN ACCORDANCE WITH THE PROVISIONS OF TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE II OF THE AMERICANS WITH DISABILITIES ACT OF 1990, THE AGE DISCRIMINATION ACT OF 1975, AND THE REGULATIONS OF THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES ISSUED PURSUANT TO THESE STATUTES AT TITLE 45 CODE OF FEDERAL REGULATIONS (CFR) PARTS 80, 84, AND 91, AND 28 CFR PART 35, THE OMNIBUS CRIME CONTROL AND SAFE STREETS ACT OF 1968, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, EQUAL TREATMENT FOR FAITH-BASED RELIGIONS AT 28 CFR PART 38, THE VIOLENCE AGAINST WOMEN REAUTHORIZATION ACT OF 2013, AND SECTION 1557 OF THE AFFORDABLE CARE ACT.

45. Would you like to Register to Vote?

Applying to register or declining to register to vote will not affect the amount of assistance that you are provided by this agency.

If you are not registered to vote where you live now, would you like to apply to register to vote here today?

☐ YES ☐ NO

If you do not check either box, you will be considered to have decided NOT to register to vote at this time.

(Failure to check either box is deemed a declination to register for purposes of receiving assistance in registration but is not deemed a written declination to receive an application. If you do not check either box, you will be provided a voter registration form that you may complete at your convenience.)

If you register to vote, the information regarding the office to which the voter registration form was submitted will remain confidential and be used only for voter registration purposes. If you do not register to vote, this decision will remain confidential and be used only for voter registration purposes. If you would like help filling out the voter registration form, we will help you. The decision whether to seek or accept help is yours. You may fill out the voter registration form in private.

If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with the South Dakota Secretary of State, 500 E Capitol, Pierre SD 57501, (605) 773-3537.

46. Authorization to Release Information

I, _____, authorize the Department of Social Services (DSS), Division of Economic Assistance (EA) to disclose my protected health information to the following individual/facility. My date of birth is: _____

Individual/Facility and Name of Facility Person to Receive Information: _____
Address: _____
Phone Number: _____
Fax Number: _____

This authorization is for the time period from: _____ to _____. If left blank, this authorization shall expire 1 year from the date of execution.

I allow DSS-EA to release only the following checked information to the above strategy: (check all that apply)
☐ Copy of Application/Renewal Form Dated: Month(s) _____ Year(s) _____ ☐ Address on File
☐ Copy of Notices from DSS-EA Relating to Application/Renewal Form Dated: Month(s) _____ Year(s) _____
☐ Copy of Verification Checklist Form (EA-300) Dated: Month(s) _____ Year(s) _____

Purpose of this disclosure:
I understand if this information is released to a third party, the information may be released by the person or entity that receives that information may no longer be protected by federal or other applicable privacy regulations.

I understand that I may revoke this authorization, except to the extent that staff has already taken action upon it, by sending written notice to the Department of Social Services, Division of Economic Assistance, 700 Governors Drive, Pierre, SD 57501.

I understand that I am under no obligation to sign this authorization. If the information requested is necessary to determine if I am eligible to enroll in benefits available through the South Dakota Department of Social Services or to determine if another medical program can pay for my health care, I understand that if I choose not to authorize the disclosure and use of this information, I may not be able to show that I qualify.

Signature	Printed Name	Date
Address of Individual Signing	City/State/Zip	Phone

If signed by someone other than Applicant/Recipient indicate relationship (check appropriate box)

☐ Spouse ☐ Parent (if for child under 18) ☐ Power of Attorney ☐ Legal Guardian

47. Authorization for the Use or Disclosure of Protected Health Information

As required by the Health Insurance Portability and Accountability Act of 1996, as amended, the South Dakota Department of Social Services, Division of Economic Assistance may not use or disclose your personally identifiable health information, except as provided in our Notice of Privacy Practices, without your authorization. Your signature on this form indicates that you are giving permission for the uses and disclosures of protected health information described herein. You may revoke this authorization at any time by signing and dating the revocation section on your copy of this form and return it to the Department.

Section 1: Patient Information – I,

Patient Name:		**Date of Birth:**	_____/_____/_____
Address:			
City, State, ZIP:		**Phone:**	

hereby authorize the following individual(s) or entity(ies) to release the information described in Section 2 of this Authorization, to the persons, entities or classes of persons or entities listed in Section 3 of this Authorization: *(list <u>all</u> medical, psychological, educational, therapeutic, or other providers below)*

Facility Name:		**Facility Name:**	
Facility Name:		**Facility Name:**	

Section 2: Information Requested	**Section 3: Recipient Information: The specific information is to be released to the following person, entity(ies), or class(es) of person(s) or entity(ies):**
<u>Specific Information Requested</u>: ALL RECORDS <u>Specific dates of service for the information requested</u>: LAST 12 MONTHS AND FUTURE VISITS **<u>Purpose of the disclosure</u>:** MEDICAID ELIGIBILITY	<u>SOUTH DAKOTA DEPARTMENT OF SOCIAL SERVICES</u>

Section 4: Disclosures

I understand the information received may include information relating to drug and/or alcohol abuse or physical/sexual abuse. The South Dakota Department of Social Services, its employees, officers, and medical providers are hereby released from any legal responsibility or liability for release of the above information to the extent indicated and authorized herein.

As stated in the Department's Notice of Privacy Policies, this consent form may be revoked at any time except to the extent the staff has taken action upon it. If not revoked, this Authorization to release protected health information will terminate in one year or upon the following specified date:_____/_____/_____. I understand that this authorization may be revoked at any time, as long as I do so in writing.

I understand if this information is released to a third party, the information may be released by the person or entity that receives the information and may no longer be protected by federal or other applicable privacy regulations. Exception -- drug and/or alcohol treatment information, HIV testing information, and mental health treatment information may not be re-disclosed without my specific consent.

I understand that I am under no obligation to sign this authorization. If the information requested is necessary to determine if I am eligible to enroll in benefits available through the South Dakota Department of Social Services or to determine if another medical program can pay for my health care, I understand that if I choose not to authorize the disclosure and use of this information, I may not be able to show that I qualify. If the South Dakota Department of Social Services has been asked to allow or pay for a health care service on my behalf (such as a test or evaluation) for the purpose of providing the results of those services to someone else, I understand that if I choose not to authorize the disclosure of that information to the other person, the Department of Social Services may not allow the service or the payment for services provided on my behalf.

Signatures

Signature of patient, parent, guardian, or authorized representative **Date**

Printed name of patient, parent, guardian, or authorized representative **Relationship to patient**

Phone number of the patient, parent, guardian, or authorized representative
If signed by a personal representative, provide verification of the representative's authorization to act for the patient

REVOCATION OF AUTHORIZATION

I hereby cancel this request to release information effective immediately

Signature **Date**

48. Completing your Application (Required)

PRIOR TO SIGNING THE APPLICATION BELOW, PLEASE VERIFY THAT YOU HAVE DONE THE FOLLOWING:

1. INCLUDED ALL OF THE APPLICABLE ITEMS REQUESTED WITH YOUR APPLICATION (E.G. BANK STATEMENTS, AWARD LETTERS, TRUSTS, BURIAL CONTRACTS, AND REAL ESTATE TAX ASSESSMENTS);
2. REVIEWED THE STATEMENT OF UNDERSTANDING;
3. COMPLETED THE AUTHORIZATION FOR THE USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION; AND
4. COMPLETED "AUTHORIZATION TO RELEASE INFORMATION" IF YOU WANT THE DEPARTMENT TO SHARE INFORMATION ABOUT YOUR APPLICATION WITH SOMEONE ELSE.

49. Sign and Authorize Application (Required)

I UNDERSTAND THAT ANY FALSE STATEMENTS WHICH I MAY MAKE AND ANY FAILURE ON MY PART TO REPORT ANY CHANGE IN CIRCUMSTANCE WHICH WOULD AFFECT MY ELIGIBILITY FOR PAYMENT FROM PROGRAMS ADMINISTERED BY THE SOUTH DAKOTA DEPARTMENT OF SOCIAL SERVICES CONSTITUTES A CRIME AND THAT I COULD BE PROSECUTED UNDER SOUTH DAKOTA CRIMINAL LAWS.

I AGREE TO PROVIDE INFORMATION UPON REQUEST FROM THE DEPARTMENT OF SOCIAL SERVICES CONCERNING ANY ASSET OR ESTATE WHICH MAY BE SUBJECT TO RECOVERY, ESTATE RECOVERY, OR MEDICAL ASSISTANCE LIENS BY THE STATE OF SOUTH DAKOTA.

I HEREBY AUTHORIZE ANY PERSON, AGENCY, OR INSTITUTIONS TO SUPPLY INFORMATION REQUESTED BY THE DEPARTMENT OF SOCIAL SERVICES CONCERNING ME OR MY FAMILY AND ALLOW INSPECTION AND REPRODUCTION OF THE RECORDS IN HIS OR THEIR POSSESSION PERTAINING TO ME OR MY FAMILY BY ANY DULY AUTHORIZED REPRESENTATIVE OF THE DEPARTMENT. I FURTHER AUTHORIZE THE DEPARTMENT TO RELEASE SUCH INFORMATION TO PROVIDERS OR COOPERATING STATE OR FEDERAL AGENCIES.

THIS AUTHORIZATION IS GIVEN ONLY IN CONNECTION WITH ITS USE BY THE DEPARTMENT IN THE ADMINISTRATION OF ITS PROGRAMS AND FOR NO OTHER PURPOSE. IT SHALL CONTINUE IN EFFECT UNTIL SUCH TIME AS I STATE IN WRITING THAT IT IS NO LONGER VALID.

I THEREWITH RELEASE ANY PERSON, AGENCY, OR INSTITUTION FROM ANY AND ALL LIABILITY TO ME OR MY FAMILY FOR SUPPLYING SUCH INFORMATION.

APPLICANT	SPOUSE
SIGNATURE	SIGNATURE
PRINT NAME	PRINT NAME

IF YOU ARE A PARENT, GUARDIAN, AUTHORIZED REPRESENTATIVE, COURT APPOINTED ADMINISTRATOR, EXECUTOR, OR HAVE POWER OF ATTORNEY FOR THIS PERSON, SIGN BELOW:

SIGN HERE (MUST PROVIDE PROOF)

SIGN HERE IF YOU ARE A WITNESS (ONLY NEEDED IF ANYONE ABOVE SIGNED WITH AN "X" OR OTHER MARK)

PRINTED NAME OF WITNESS